Community Services Reimbursement Rate Commission

ANNUAL REPORT

Executive Summary

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COMMUNITY SERVICES REIMBURSEMENT RATE COMMISSION

Membership

Theodore N. Giovanis, FHFMA, M.B.A., Chairman
Alan C. Lovell, Ph.D., Vice Chairman
Jean M. Frank, B.S.
Jerry Lymas, B.A., J.D.
John Plaskon, B.S., M.S.
Queenie Plater, B.S., M.S.
Lori Somerville, B.S., M.S.

Community Services Reimbursement Rate Commission
11141 Georgia Avenue, Suite 517
Wheaton, Maryland 20902-4680

301-946-9790
800-646-7332
240-248-0057 FAX
CSRRC@aol.com

(Note: Biographical sketches are included as Appendix A.)

REPORTING REQUIREMENTS

On or before October 1 of each year the Commission shall issue a Report to the Governor, the Secretary, and, subject to paragraph 2-1246 of the State Government Article, the General Assembly that:

1. Describes its findings regarding:

(I) The relationship of changes in wages paid by providers to changes in rates paid by the Department;

(II) The financial condition of providers and the ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest;

(III) The incentives and disincentives incorporated in the rate setting methodologies utilized and proposed by the Mental Hygiene Administration and the Developmental Disabilities Administration and how the methodologies might be improved;

(IV) How incentives to provide quality of care can be built into a rate setting methodology; and

(V) The recommended methodologies for the calculation of rate update factors and the rate update factors recommended for the next succeeding fiscal year.

2. Recommends the need for any formal executive, judicial, or legislative actions;

3. Describes issues in need of future study by the Commission; and,

4. Discusses any other matter that relates to the purposes of the Commission under this subtitle.

In addition, in the report due on or before October 1, 2002 and October 1, 2005 the Commission shall include its findings regarding the extent and amount of uncompensated care delivered by providers.

Executive Summary

The State of Maryland desires an environment for citizens with developmental disabilities and mental illness that ensures quality, equity, and access to services and financial resources. The Commission believes that the State is committed to a system that provides quality care and that is fair to efficient and effective providers. As the human services and health care markets change and as changing demands are placed on the providers of services, it is important to ensure the continued successful operation of providers within a reasonable budgetary framework.

The Commission was established by the Maryland legislature in 1996, so has been in operation for 7 years. Each year the Commission publishes an Annual Report on its activities, findings, and recommendations. This is the seventh such Annual Report. The Commission consists of 7 members, appointed by the Governor, and with the advice and consent of the Senate.

Through July 1999 the Community Services Reimbursement Rate Commission (CSRRC) met monthly to address its charges as outlined in Senate Bill 685 (1996). These charges were modified by Senate Bill 448 (1999) and further by House Bill 454 (2002). At the July 1999 meeting the Commission decided that it would be more productive to establish Technical Advisory Groups (TAG) and to replace two thirds of the formal Commission meetings with TAG meetings. The first set of TAG meetings was held in August 1999, and this structure has proved to be quite productive so the Commission has continued to use it. The topics covered in the TAG meetings have included:

- design of wage surveys to collect wage rate and staff turnover information from providers, and the interpretation of the data collected by these surveys;
- the definition of uncompensated care, and the design of surveys to collect data on uncompensated care and related issues from providers, and the interpretation of the results of these surveys;
- the financial condition of the providers;
- the structure of updating systems; and,
- the measurement of quality and outcomes, and how incentives to improve quality can be built into the payment system.

The Commission devoted its December 4, 2000 meeting to quality issues in services for individuals with developmental disabilities, and its January 8, 2001 meeting to quality issues in mental health services, with presentations by invited speakers and discussions with providers. A paper discussing quality measurement and how to build incentives for quality into the payment system is being prepared, and drafts have been discussed with the TAGs.

Staff has prepared several briefing and issue papers, some of which are attached in Appendix B. This report also offers the Commission's observations with regard to funding and payment methodology, the adequacy of the rates and rate updates, new system transitions, social policy, provider efficiency, and quality and outcomes. The Commission remains committed to providing constructive recommendations to the Governor, the General Assembly, and the Secretary in a timely manner. It should be noted that the recommendations have been developed in a balanced manner; the report should thus be considered as a unit rather than as a set of individual recommendations.

Key findings from the past year include the following:

- Neither the DDA nor the MHA payment systems include systematic mechanisms to adjust rates for inflation and other factors. Such adjustment mechanisms should be developed and implemented. The Commission has designed a suitable system, and calculated the update factor that would result from its application.

- The salary levels paid by DDA providers and in a number of MHA community service employment categories are lower than the corresponding salaries of State employees, particularly when fringe benefits are taken into account.

- The collection of uniform data on an ongoing basis is needed to monitor, compare, and evaluate the present and new payment systems in the context of the Commission's statutory authority as well as DDA and MHA responsibilities to monitor the system. The data submission from the providers has substantially improved in the past year.

- The measurement of quality of services and of outcomes are still at a developmental stage. It would be premature to base payments on specific measurements of quality and outcomes.

- The psychiatric rehabilitation providers paid by MHA and the providers paid by DDA have increased the wages for direct care workers over the past three years by more than the change in the rates they have received from MHA and DDA, respectively.

Both MHA and DDA have promulgated regulations requiring the submission of wage surveys and other data. The data that will be submitted pursuant to these regulations is expected to greatly assist the Commission in its analyses.

Social Policy Choices

The context in which social policy choices are made needs to be examined. For example, historically there have been lists of clients waiting to receive services, and providers are requesting higher rates to care for existing consumers and to make investments in quality. It was anticipated that, for DDA, this conflict between improving services to existing clients versus serving more clients would begin to be resolved by the Governor's waiting list reduction initiative. However, the waiting lists appear to be increasing again.

In MHA, the system was expanded to serve more individuals without Medicaid who are eligible for public subsidies for selected services, but there was no corresponding increase in the overall budget. Such expansions could risk jeopardizing quality and potentially reducing services to those most in need (populations historically targeted for services by the public mental health system). In fact, MHA is responding to ongoing budget overruns by cutting back on gray area eligibility. Choices such as covering new clients, dropping clients from coverage, or ensuring stability for existing providers need to be made consciously. MHA has described the context for its decision making in the values set forth in its 5-year plans. DDA's planning efforts are directed by the goals of its self-determination project and its waiting list initiative.

The Commission will continue to look into these issues in the coming year.

The Financial Condition of the Providers

In considering the results reported here it should be kept in mind that our assessment of the financial condition of the providers is based on available data, which involves a lag of more than a year. The bulk of the psychiatric rehabilitation providers contracting with MHA appear to be in a stable financial situation. The majority of the providers contracting with DDA have a positive margin, but the mean margin dropped to about 1% in fiscal year 2001. A majority of the outpatient mental health clinics (OMHC) are losing money, and have cash flow problems. Their situation is sufficiently serious that access to care could be threatened in some areas of the state. The financial condition of the OMHCs will be exacerbated by reductions in gray area eligibility, and by reductions in Medicare payments rates for 2002, with further reduction expected for 2003. These effects will be somewhat mitigated by rate increases provided by MHA to some OMHC rates effective July 1, 2002.

In accordance with the legislative requirement to assess "the financial condition of providers and the ability of providers to operate on a solvent basis in the delivery of effective and efficient services that are in the public interest," the Commission intends to maintain a close watch on the financial condition of the providers by obtaining updated information as soon as it becomes available, replicating the analyses reported here, and reporting the results in interim work papers.

Recommendations

Separate sets of recommendations are being made for MHA and for DDA related issues, although there is overlap between these two sets of recommendations. These recommendations are listed in priority order.

CSRRC Recommendations pertaining to MHA

1. The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to implement the rate updates recommended by the Commission.

A systematic approach to adjusting rates for the reasonable impact of inflation and other factors is included in most national and state payment systems. As required by the legislature the Commission has prepared a paper suggesting a design for such a system, and quantifying the update factor. These recommendations should be implemented.

The community services rates paid by MHA were increased in fiscal years 1999 and 2000. However, the MHA regulations and the budget process do not include any systematic approach to updating of rates from year to year. Wages are a substantial portion of provider costs, so uncertainty in the magnitude and availability of rate increases makes it difficult for providers to plan pay raises and hiring for the subsequent year and manage their business. This may exacerbate hiring or turnover issues.

Almost all payment systems include a system for adjusting the rates to account for the impact of inflation in the prices of the goods and services purchased by the providers, among other factors. For example, the Health Services Cost Review Commission has such a system for updating the rates of the hospitals, and all the Medicare Prospective Payment Systems include such a system. DHMH has an updating system for the rates paid for medical day care. Such systems can be quite simple or relatively complex.

MHA should have some flexibility in how the rate increase is applied, so that some rates may be increased by more than the overall change, and some by less, to deal with problems of inequities in existing rates. In addition, the rates should be reviewed on a periodic basis to determine the appropriateness of the overall level of rates, and the relationship between the rates. MHA should continue to examine issues regarding individual rates or classes of services, and work to remedy these problems.

The change in rates developed through the updating system should be taken into account in the development of the MHA budget.

The Commission continues to be concerned about specific rates, for example, the PRP and OMHC rates for children given the large amount of service coordination they require. MHA does pay a higher rate for children's OMHC services, so the question there is whether that differential is sufficient to account for the higher staffing and/or greater amount of coordination

that is required when providing services to children. PRP's do not receive a higher rate for services to children, although greater coordination is also required in that setting.

2. Uncompensated care (both for clients with no insurance and for clients with inadequate insurance) and inadequate payments for Medicare and Medicare/Medicaid beneficiaries are of major concern. As a partial remedy the Medicaid payments for dual eligibles should be increased to result in total payments of the Medicaid fee schedule amount.

The high copayments required by Medicare are often raised as an issue, as are the low overall payment rates for clients who are eligible for both Medicare and Medicaid. The Commission's survey confirmed that both of these are sources of uncompensated care. Last year a bill to provide increased Medicaid payments for dual eligible beneficiaries failed in the legislature. However, this is an important issue and the legislature should reconsider increasing the level of payments for Medicare copayments for clients who are dually eligible for Medicaid and Medicare.

Uncompensated care is a growing problem for the providers, particularly with the reductions being made in gray zone eligibility. Uncompensated are occurs as a result of clients who have no insurance, and clients who have some health insurance, but that insurance either does not cover the services, or involves copayments and deductibles that the client is unable or unwilling to pay.

3. The legislature should reverse the requirement that MHA pay for gray zone services through grants or contracts and allow MHA to pay for such services through the fee-for-service system. The requirement that payments must be through grants or contracts is unduly restrictive and adds administrative complexity for both MHA and the providers.

The requirement that gray zone services may not be paid through the fee-for-service system requires that contracts be developed with all providers treating gray zone clients, however small the revenue involved. This provision is unlikely to save much money given that gray zone payments represent only 8% of the total MHA payments, and is burdensome for both MHA and the providers, particularly OMHCs that see a small number of gray zone clients. MHA should be allowed some flexibility in how they pay for services to gray zone clients. The providers are required to dummy bill in order that the services being provided can be tracked, and payments are reconciled with the dummy billings every couple of months. The interim payments were based on data for fiscal year 2001, and so can be substantially out of alignment with the services currently being provided.

Commission Recommendations pertaining to DDA

1. The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to implement the rate updates recommended by the Commission.

In general the increases provided to DDA providers have often been tied to the cost of living increases provided to state workers and only have applied it to the wage and salary component of the provider costs. The providers have, thus, not been recompensed for inflation on other components of their costs. However, there is no systematic approach to providing rate increases for the providers. Additionally, the weights used to calculate the Fee Payment System (FPS) payment have not been updated. If the weights are no longer appropriate, this could result in under- or overpayment for services. Consequently, underfunding could be confused with problems in the FPS payment methodology.

Almost all payment systems include a system for adjusting the rates to account for the impact of inflation in the prices of the goods and services purchased by the providers, among other factors. For example, the Health Services Cost Review Commission has such a system for updating the rates of the hospitals, and all the Medicare Prospective Payment Systems include such a system. DHMH has an updating system for the rates paid for medical day care. Such systems can be relatively simple or quite complex.

The community services budget of DDA was increased in fiscal years 1999, 2000, 2001 and 2002 partly for rate increases and partly because the number of people served has increased. However, the DDA regulations and the budget process do not include any systematic approach to updating of rates from year to year. Wages are a substantial portion of provider costs so uncertainty in the magnitude and availability of rate increases makes it difficult for providers to plan pay raises and hiring for the subsequent year and manage their business. This may exacerbate hiring or turnover issues. In addition, a systematic approach to the updating of rates is the only way to ensure the long term viability of these services.

DDA should have some flexibility in how the rate increase is applied, so that some rates may be increased by more than the overall change, and some by less, to deal with problems of inequities in existing rates. In addition, the rates should be reviewed on a periodic basis to determine the appropriateness of the overall level of rates, and the relationship between the rates.

The change in rates developed through the updating system should be taken into account in the development of the DDA budget.

2. The legislature should preserve the additional funds to be provided to increase the wages and fringe benefits being paid to direct care workers.

The Commission's wage survey confirmed that the wage rates and the level of fringe benefits of direct care workers, while greater than the nominal wage rates used by DDA to build up the payment rates, are substantially below the wages and fringe benefits paid to corresponding state workers. The legislature, in the DDA budget language, required DDA to develop a plan to provide additional funds to the providers, with the goal of increasing the wages and fringe

benefits being paid to direct care workers. The Commission believes that it is important to continue with the planned rate increases when quantified by DDA.

The Commission's most recent analysis of the financial condition of the providers shows a weak and deteriorating financial condition. The median margin dropped from about 3.2% in FY 2000 to about 0.7% in FY 2001. The providers have given wage increases in excess of the rate increases, and this has eroded their profit margin.

Commission Activities

Commission meetings and Technical Advisory Group (TAG) meetings are generally held the first Monday of each month unless that is a holiday. Commission meetings generally run from 1 p.m. to 3 p.m. The Mental Hygiene Administration TAG meetings runs from 1 p.m. to 3 p.m. and the Developmental Disabilities Administration TAG meetings from 3 p.m. to 5 p.m. The meetings are held at:

The Meeting House
Oakland Mills Interfaith Center
5885 Robert Oliver Place
Columbia, Maryland

Commission meetings were held on, or are scheduled for, the following dates:

January 7, 2002
February 4, 2002
June 3, 2002
September 9, 2002
December 2, 2002
January 6, 2003
April 7, 2003
September 8, 2003
December 1, 2003

Technical Advisory Group meetings were held on, or are scheduled for:

March 4, 2002
April 1, 2002
May 6, 2002
August 5, 2002
October 7, 2002
November 4, 2002
February 3, 2003
March 3, 2003
May 5, 2003
June 2, 2003
August 4, 2003
October 6, 2003
November 3, 2003

Biographical Sketches of Community Services Reimbursement Rate Commission Members

Jean Marie Frank, B.S.

Jean Frank worked for more than 27 years for the Social Security Administration (SSA). Her experience at SSA included work in disability operations and disability systems. She retired while holding the position of Director of the Division of Planning and Control in the Office of Systems Requirements.

Ms. Frank received a B.S. in Social Studies from the Johns Hopkins University and a B.S. in Food Science from the University of Maryland, College Park.

Theodore N. Giovanis, FHFMA, M.B.A.

Theodore Giovanis is President of T. Giovanis & Company, a consulting firm specializing in legislative, regulatory, and strategic consulting with an emphasis on health care policy. He has served as a technical resource for congressional staffs and the Administration. In addition to extensive consultant experience in health care financing, regulation, and policy, he has served as Director of the Health Care Industry Services of Deloitte & Touche, Director for Regulatory Issues of the Healthcare Financial Management Association, and Assistant Chief of the Maryland Health Services Cost Review Commission.

Mr. Giovanis received an M.B.A. in management from The University of Baltimore and is a fellow in the Healthcare Financial Management Association (HFMA). He is also certified in managed care.

Alan C. Lovell, Ph.D.

Alan C. Lovell is currently the Chief Executive Officer of CHI Centers, Inc., "supporting people with disabilities since 1948," a multi-purpose, community-based organization serving children and adults with disabilities. He has served in numerous leadership positions, including President and Chair with the Maryland Association of Community Services, the Maryland State Developmental Disabilities Council and the Montgomery County Interagency Coordinating Committee for People with Developmental Disabilities (InterACC/DD).

Dr. Lovell received his Ph.D. in public administration from Kensington University.

Jerry Lymas, B.A., J.D.

Jerry Lymas is currently the President of the Justin Development Group, Inc., a Neighborhood development firm specializing in neighborhood real estate development, construction management, facilities management, and development for churches through the Justin Development Group 50 Churches 50 Corners Program. Prior to that he was Special Assistant to The Honorable Parren J. Mitchell on matters relating to housing and development. He served in the U.S. Army, reaching the rank of First Lieutenant.

Mr. Lymas received his B.A. from Morgan State University in history, and his J.D. from the

University of South Carolina Law School.

Queenie C. Plater, B.S., M.S.

Queenie Plater is currently the Director of Employment and Employee Relations at Sibley Hospital in Washington, D.C.. Ms. Plater has held a few position in Human Resources at Sibley during the past 12 years. Her experience ranges from recruitment and retention, benefits, through compensation and employee relations. As EEO Officer at the hospital she represents the hospital at hearings and advises managers on policy interpretation and administration.

Ms. Plater received her B.S. in Organizational Management from Columbia Union College, and her M.S. in Applied Behavioral Science from Johns Hopkins University.

John Plaskon, B.S., M.S.

John Plaskon is currently the Executive Director of Crossroads Community, Inc., a position he has occupied for 13 years. He also serves on the Boards of The Maryland Association of Non-Profit Organizations, The Upper Shore Community Mental Health Center, Shore Leadership, and the Queen Anne's County Local Management Board. Previous experience includes having been a Developmental Disabilities Coordinator on the Eastern Shore, Program Director for Channel Marker, and a Rehabilitation Counselor in New Jersey.

Mr. Plaskon received his B.S. in meteorology from Rutgers University , and an M.S. in educational psychology from Texas A&M, as well as a certificate in administrative practice from UMBC.

Lori Somerville, B.S., M.S.

Lori Somerville is currently the Chief Operating Officer of Humanim. Humanim is a private, non-profit organization that provides clinical, residential, and vocational services to children and adults with disabilities. Prior to serving as COO, Lori served as the Director of Human Resources. She came to Humanim in 1998 by way of a merger with Vantage Place, a residential program for adults with psychiatric disabilities and adults with brain injuries. Lori had spent fourteen years at Vantage Place and over 6 as the Executive Director. She is a graduate of Leadership Howard County and currently serves on the board of Children of Separation and Divorce. Lori's previous experience includes serving on the Community Behavioral Health Association Board of Directors and serving as President of the Association of Community Services and Supported Living Boards.

Lori received her undergraduate degree from Towson State in Psychology and a Master's from Johns Hopkins in Organizational Development.

STATUS OF 2002 RECOMMENDATIONS

CSRRC Recommendations pertaining to MHA

1. The State is considering a variety of possible actions that would have the effect of reducing projected aggregate payments to providers, such as cutting the level of authorized services for community service providers, and cutting back on gray area eligibility in order to mitigate the budget shortfall. These reductions should not be made.

DHMH is projecting a substantial budget shortfall and in response to this shortfall is considering a variety of possible actions that would have the effect of reducing projected aggregate payments to providers, such as cutting the level of authorized services to be provided by community service providers and making the gray area eligibility criteria more restrictive. The financial condition of the providers, and particularly the OMHCs, is precarious, and the viability of some of the providers could be jeopardized by such cuts. Moreover, the savings in the MHA budget resulting from reductions in gray area eligibility should not be taken at face value, as they are likely to be offset by increased expenditures in other areas, for example, the criminal justice system, and increased emergency department and inpatient hospital utilization, including both general acute and state hospitals.

The Commission recommends that such cuts should not be made.

Status: The legislature mandated that MHA must pay for gray area services by means of grants or contracts, and not through the fee-for-service system. This has resulted in administrative complications for the providers, MHA and MHP, and is the subject of a recommendation in this report. The levels of authorized services have been reduced.

2. The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to issue a joint report by July 1 of each year to the Governor and the Joint Chairmen of the legislative committees responsible for the MHA budget. The report should specify the level of updating recommended for the upcoming year for community services rates paid by MHA and the rationale for this level.

A systematic approach to adjusting rates for the reasonable impact of inflation and other factors is included in most national and state payment systems, and should be developed and implemented for establishing the rates for MHA community services, and in developing the MHA budget. In addition, the base rate in the fee schedule should be reviewed for adequacy on a periodic basis.

The community services rates paid by MHA were increased in fiscal years 1999 and 2000. However, the MHA regulations and the budget process do not include any systematic approach to updating of rates from year to year. Wages are a substantial portion of provider costs, so uncertainty in the magnitude and availability of rate increases makes it difficult for providers to plan pay raises and hiring for the subsequent year and manage their business. This may exacerbate hiring or turnover issues.

Almost all payment systems include a system for adjusting the rates to account for the impact of inflation in the prices of the goods and services purchased by the providers. For example, the Health Services Cost Review Commission has such a system for updating the rates of the hospitals, and all the Medicare Prospective Payment Systems include such a system. DHMH has an updating system for the rates paid for medical day care. Such systems can be quite simple or relatively complex. It is difficult to understand why the State has not incorporated such a system for community services paid for by MHA.

In developing the update factors DHMH should take into account such factors as the differential in wage rates including fringe benefits between direct care workers who work in community service providers and the corresponding state workers, the inflation rate in relevant wages, the impact of inflation on the cost of the goods and services being purchased by the providers, changes in the nature of the services being provided, geographic differences in labor costs, and system-wide productivity improvements. Alternatively, the updated rates could be based on a re-evaluation of the rates being paid for the services by private payers, where this is applicable. The systematic approach would be established with factors to be used in calculating the update amount published several months prior to the fiscal year for which they will be applied in order to provide advance notice to the providers and allow for management responses to the anticipated changes. The change in rates developed through the updating system should be taken into account in the development of the MHA budget.

The basis for the adjustment should be one of the nationally available indices of inflation, or a combination of such indices. Examples include the increase in the Baltimore or national Consumer Price Index (CPI), the increase in the medical care component of the CPI, or two thirds of the increase in service worker wages plus one third of the increase in the CPI. In addition, adjustments should be made to the inflation factor to account for unusual costs that impact the providers more or less than they impact the general inflation indices, changes in regulations that impose additional costs on providers, or reduce their costs, and expected productivity improvements.

MHA should have some flexibility in how the rate increase is applied, so that some rates may be increased by more than the overall change, and some by less, to deal with problems of inequities in existing rates. In addition, the rates should be reviewed on a periodic basis to determine the appropriateness of the overall level of rates, and the relationship between the rates.

Because of the budget process in Maryland, and to assure the appropriate level of review, the Commission believes that the most appropriate approach is one in which the Governor receives advice on this issue, and that the approach should involve the Legislature. Therefore, the Commission recommends that the Governor direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to jointly issue a report by July 1 of each year specifying the level of updating recommended for the upcoming year for community services rates paid by MHA, and that this report be provided to the Governor and the Joint Chairmen of the legislative committees overseeing the MHA budget for their consideration in the budget process. The Commission believes that: 1) an examination of the appropriate level of updating and the rationale for that level; 2) a sharing of that analysis with the appropriate parties; and 3) interaction in the budget process, creates an environment that will achieve the best result.

Status: This recommendation has not been implemented. However, the legislature did modify the Commission's enabling legislation to require that the Commission design an updating system, and recommend annually an update factor. The required paper is attached as Appendix B-3 to this Annual Report.

3. MHA should continue to examine issues regarding individual rates or classes of services, and work to remedy these problems. In addition, uncompensated care and inadequate payments for Medicare and Medicare/Medicaid beneficiaries are of major concern, as are copayments for gray zone clients and uncompensated care for clients with private insurance. As a partial remedy the Medicaid payments for dual eligibles should be increased to result in total payments of the Medicaid fee schedule amount.

The Commission continues to be concerned about specific rates, for example, the PRP and OMHC rates for children given the large amount of service coordination they require. MHA does pay a higher rate for children's OMHC services, so the question there is whether that differential is sufficient to account for the higher staffing and/or greater amount of coordination that is required when providing services to children. PRP's do not receive a higher rate for services to children, although greater coordination is also required in that setting.

The high copayments required by Medicare are often raised as an issue, as are the low overall payment rates for clients who are eligible for both Medicare and Medicaid. The Commission's survey confirmed that both of these are sources of uncompensated care. A bill to provide increased Medicaid payments for dual eligible beneficiaries failed in the legislature last year. However, this is an important issue and the legislature should reconsider increasing the level of payments for Medicare copayments.

Uncompensated care is likely to become an even more important issue for providers with the cutbacks that are currently being made in gray area eligibility. This will adversely affect their financial performance.

Status: MHA has had a consultant examining rates, with particular emphasis on children's rates, and is currently engaged in a detailed cost study to determine the adequacy of the rates. Substantial increases were provided in certain rates effective July 1, 2002 to deal with the type of problems discussed above. No progress has been made on dealing with the issue of low levels of payment for dual eligible Medicare/Medicare beneficiaries. Reductions in gray area eligibility are likely to further exacerbate the uncompensated care problems.

4. MHA should monitor the financial condition of the providers, to ensure that financial issues are not likely to interfere with access to, or the continuity and quality of care. MHA should check on the financial status of providers who are reporting that they are in poor financial condition, and provide additional support on billing and other issues, as appropriate.

The Commission understands that MHA is already providing some consulting assistance to providers in need of such help and that providers may decline assistance that is offered. Never the less, the Commission believes that a more formalized systematic analysis and review with targeted assistance is appropriate and timely. The Commission would offer its assistance to work with MHA in the development of such a process.

Status: The legislature required that MHA collect financial reports. MHA has requested that the CSAs provide the financial reports of their providers to the CSRRC so that an analysis of financial condition can be undertaken. To date about 40 financial reports have been made available and CSRRC staff is analyzing data extracted from these reports. MHA has engaged a consultant to survey providers, and study their rates and costs. MHA has provided technical support to some providers.

Commission Recommendations pertaining to DDA

1. The State is experiencing budget problems and may consider a variety of possible actions that would have the effect of reducing projected aggregate payments to community providers. Such cuts should not be made.

DHMH is projecting a substantial budget shortfall and in response to this shortfall may consider a variety of possible actions that would have the effect of reducing projected aggregate payments to community providers. The financial condition of some of the providers could be jeopardized by such cuts. While the analysis of the financial condition of the providers shows them to be making a small profit, 25% of the providers were incurring losses, and reductions in rates would likely increase that percentage. As a result the Commission recommends that such cuts should not be made.

Status: No reductions to DDA rates or payments were made. In fact, rates were increased effective July 1, 2002.

2. The Governor should direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to issue a joint report by July 1 of each year to the Governor and the Joint Chairmen of the legislative committees responsible for overseeing the DDA budget. The report should specify the level of updating recommended for the upcoming year for community services rates paid by DDA and the rationale for this level.

A systematic approach to adjusting rates for the reasonable impact of inflation and other factors is included in most national and state payment systems and should be developed and implemented for establishing the rates paid for DDA community services, and accordingly used in developing the DDA budget.

The DDA budget for FY 1999 included funds to update the rates and to reduce the waiting list, and the FY 2000 budget included a cost of living adjustment for wages, a rate increase, and additional funds for the Governor's waiting list initiative. Rates were also increased for FY 2001 and FY 2002. In general the increases provided to DDA providers have often been tied to the cost of living increases provided to state workers. However, there is no systematic approach to providing rate increases for the providers. Additionally, the weights used to calculate the Fee Payment System (FPS) payment have not been updated. If the weights are no longer appropriate, this could result in under- or overpayment for services. Consequently, underfunding could be confused with problems in the FPS payment methodology.

Almost all payment systems include a system for adjusting the rates to account for the impact of

inflation in the prices of the goods and services purchased by the providers. For example, the Health Services Cost Review Commission has such a system for updating the rates of the hospitals, and all the Medicare Prospective Payment Systems include such a system. DHMH has an updating system for the rates paid for medical day care. Such systems can be relatively simple or quite complex. It is difficult to understand why the State has not incorporated such a system for community services paid for by DDA.

The community services budget of DDA was increased in fiscal years 1999, 2000, 2001 and 2002 partly for rate increases and partly to increase coverage. However, the DDA regulations and the budget process do not include any systematic approach to updating of rates from year to year. Wages are a substantial portion of provider costs so uncertainty in the magnitude and availability of rate increases makes it difficult for providers to plan pay raises and hiring for the subsequent year and manage their business. This may exacerbate hiring or turnover issues. In addition, a systematic approach to the updating of rates is the only way to ensure the long term viability of these services.

In developing the update factor DHMH should take into account the inflation rate in relevant wages, the impact of inflation on the cost of the goods and services being purchased by the providers, changes in the nature of the services being provided, the funds being provided to increase direct care worker wages, and system-wide productivity improvements. The systematic approach would be established with the specific factors to be used in calculating the update amount published several months prior to the fiscal year for which they will be applied in order to provide advance notice to the providers and allow for management responses to the anticipated changes. The basis for the adjustment should be one of the nationally available indices of inflation, or a combination of such indices. Examples include the increase in the Baltimore or national Consumer Price Index (CPI), the increase in the medical care component of the CPI, or two thirds of the increase in service worker wages plus one third of the increase in the CPI. In addition, adjustments should be made to the inflation factor to account for unusual costs that impact the providers more or less than they impact the general inflation indices, changes in regulations that impose additional costs on providers, or reduce their costs, and expected productivity improvements.

DDA should have some flexibility in how the rate increase is applied, so that some rates may be increased by more than the overall change, and some by less, to deal with problems of inequities in existing rates. In addition, the rates should be reviewed on a periodic basis to determine the appropriateness of the overall level of rates, and the relationship between the rates.

Because of the budget process in Maryland, and to assure the appropriate level of review, the Commission believes that the most appropriate approach is one in which the Governor receives advice on this issue, and that the approach should involve the Legislature. Therefore, the Commission recommends that the Governor direct the Secretary of the Department of Health and Mental Hygiene and the Secretary of Budget and Management to jointly issue a report by July 1 of each year specifying the level of updating recommended for the upcoming year for community services rates paid by DDA, and that this report be provided to the Governor and the Joint Chairmen of the legislative committees responsible for overseeing the DDA budget for their consideration in the budget process. The Commission believes that: 1) an examination of the appropriate level of updating and the rationale for that level; 2) a sharing of that analysis with the appropriate parties; and 3) interaction in the budget process, creates an environment that will

achieve the best result.

Status: This recommendation has not been implemented. However, the legislature did modify the Commission's enabling legislation to require that the Commission design an updating system, and recommend annually an update factor. The required paper is attached as Appendix B-3 to this Annual Report.

3. The legislature should allow the providers some limited flexibility in the use of the additional funds to be provided to increase the wages being paid to direct care workers.

The Commission's wage survey confirmed that the wage rates of direct care workers, while greater than the nominal wage rates used by DDA to build up the payment rates, are substantially below the wages paid to corresponding state workers. The legislature, in the DDA budget language, required DDA to develop a plan to provide additional funds to the providers, with the goal of increasing the wages being paid to direct care workers. The Commission believes that the providers require some flexibility in their use of these funds, and that the majority, but not all, of these additional funds should be devoted to increasing direct care worker wages and fringe benefits. For example, because these increased funds are not complemented by a system of updating of rates then some of the increased funding may be required to offset inflation in the costs of goods and services other than increases in direct care worker wages. The providers require flexibility to make logical pay scale and benefit adjustments, and may have to revise the structure of their pay scales, which will take some time to plan.

Status: The providers have the flexibility to apply the additional funds to direct care wages or fringe benefits. No other flexibility has been provided.

4. Data should be collected that allows for an assessment of outcomes and quality. DDA, the provider organizations, and the Commission should work together to design this data collection process to serve the varied information needs of the parties.

In addition to the consumer satisfaction surveys discussed above, DDA should consider collecting data which allows for a comparison of outcomes, both between providers and over time. The most effective manner to collect this data should be discussed - it may be through fields added to the cost report, or a separate report distributed by DDA. DDA, the provider organizations, and the Commission should work cooperatively to design the most efficient mechanism to accomplish this goal.

Status: Data collection for assessment of outcomes is being undertaken. The Commission staff have obtained copies of Cost Reports from DDA and are currently conducting an analysis of these reports.